



Health Home Orientation

South Dakota Health Home Orientation

Introduction to Health Homes

What is a Health Home?

- Created by Section 2703 of the ACA to help reduce the cost of services for some High Cost High Risk Medicaid populations.
- Health Homes are a systematic and comprehensive approach to the delivery of primary care or behavioral health care that promises better patient experience and better results than traditional care.
- This approach is designed to affect change in a Health Home recipient's health status and to reduce utilization of high cost services.
- Six Core Services outlines by CMS and defined by the Health Home Workgroup must be provided to each Health Home recipient.

Six Core Services

- Six Core Services must be provided to the level appropriate for each recipient.
 1. Comprehensive care management
 2. Care coordination
 3. Health promotion
 4. Comprehensive transitional care/follow-up
 5. Patient and family support
 6. Referral to community and social support services

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Health Home Infrastructure

Provider Infrastructure

Primary Care

- Primary Care Physicians
- PAs
- Advanced Practice Nurses

Working in:

- Federally Qualified Health Center
- Rural Health Clinic
- Clinic Group Practice
- IHS

Behavioral Health

- Mental Health Providers
- Working in:
- Community Mental Health Centers

Health Care Team

- Care coordinator
- Chiropractor
- Pharmacists
- Support staff
- Health Coach
- Other appropriate services

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Who do Health Homes serve?

Who do Health Homes serve?

- Medicaid recipients who have...
 - Two or more chronic conditions OR one chronic and at risk for another (Defined separately):
 - **Chronic conditions include:** Mental illness, substance abuse, asthma, COPD, diabetes, heart disease, hypertension, obesity, musculoskeletal, and neck and back disorders.
 - **At risk conditions include:** Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and use of multiple medications (6 or more classes of drugs).
 - One severe mental illness or emotional disturbance.
- Eligibility based on 15 months of claims data based on diagnosis.
- Medicaid recipients that meet criteria are stratified into four tiers based on the recipient's illness severity using CDPS (Chronic Illness and Disability Payment System).

Review Flowcharts

- Attribution Flowchart
- Health Home Services Flowchart

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Core Services

Six Core Services

- CMS requires the six Core Services be provided to all enrolled recipients at a level that is appropriate for the recipient.
- Health Home minimum requirement is to provide one of the Core Services to each recipient every quarter and to have this action recorded in the Electronic Health Record. Recipient should be engaged by the action – not simply provider care conference.
- Health Homes are paid the monthly PMPM quarterly for those recipients where at least one core services was provided during the quarter. All medical services continue to be reimbursed according to the current reimbursement structure.
- DSS has developed a consistent template and method to track the Core Service delivery.

Quarterly Core Service Reporting

- DSS moving to a retrospective payment system effective January 1, 2015. Services will be provided and then after the quarter is complete, DSS will pay for all recipients where the Health Home has provided at least one core service.
- DSS will provide an excel spreadsheet of Health Home recipients for each month in the quarter.
- The Health Home will use the spreadsheet to indicate if a core service was provided (Y/N).
- If the recipient was not provided at least one core service, the Health Home will not be paid for any of the months in that quarter.
- Review reporting schedule for Quarterly Core Service Report.

Submission Deadline	Data to be Submitted
April 30, 2015	January – March 2015
July 31, 2015	April – June 2015

1. Comprehensive Care Management

- Comprehensive Care Management is the **development** of an individualized care plan with active participation from the recipient and health home team members.
- Each recipient's individual care plan is based on a comprehensive assessment with all identified issues incorporated into the care plan and documented in the EHR.
- The designated provider is responsible for providing for all of the recipient's health care needs. Takes responsibility for:
 - Arranging care as needed
 - Coordination with other qualified professionals
 - Discussing appropriate access to care (ER utilization)
 - Preventive education
 - Conducting a standard behavioral health assessment of your choosing.
- Provides same day appointments, timely clinical advice by telephone during and after office hours (24/7), and documents clinical advice in the medical record.

Key Elements of a Care Plan

- Care Plans are an integral part of serving recipients in Health Homes.
- Each clinic or Health System is allowed to choose a template for their Care Plan, but a Care Plan must be completed on each recipient in Health Homes..
- Care Plans should:
 - Include basic information about the recipient;
 - Summarize the recipient's medical conditions and medications;
 - Identify those involved (providers, family, other services);
 - Summarize recipient's social situation (housing, employment, transportation etc.);
 - Summarize recipient's barriers;
 - Establish goals to improve health and overcome barriers.
- If behavioral health needs are identified in the assessment, Care Plan should include plan to address.
- Care Plans should be developed with active participation from the recipient and natural supports of their choosing.

2. Care Coordination

- Care coordination is the **implementation** of the individualized care plan that coordinates appropriate linkages, referrals, and follow-up to needed services and supports.
- The Health Home care coordinator or Health Home team is responsible for the management of the recipient's overall care plan.
- Shares key clinic information (problem list, medication list, allergies, diagnostic test results) with other providers involved in the care of recipients.
- Integration of medical or behavioral health expertise is crucial to serve the whole person. For example, the Health Home team of a recipient with a severe mental illness who has co morbid physical conditions should include a physician or advanced practice professional as part of the team and vice versa.
- DSS nurses will conduct a random sample of case reviews to ensure care coordination is being provided.

3. Health Promotion

- Health promotion services **encourage and support** healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self manage their health.
- The Health Home care coordinator will provide health promotion activities. Specific activities may include, but are not limited to the following:
 - Provide health education to recipients and their family members specific to the recipient's chronic conditions and/or behavioral health conditions;
 - Develop disease specific self-management plans;
 - Provide education regarding the importance of immunizations and screenings, child physical and emotional development; and
 - Promote healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

4. Comprehensive Transitional Care

- Comprehensive transitional care services are a **process** to connect the designated provider team and the recipient to needed services available in the community.
- Health Home has the overall responsibility and accountability for coordinating all aspects of transitional care including transitions to home, long term care, rehab and other settings.
- Each Health Home recipient will receive a card on the bottom of the letter that confirms they are part of a Health Home and who is serving as their designated provider. Health Homes need to teach recipients the importance of sharing their Health Home card along with their Medicaid card with each provider. Additionally, they need to ask the provider to notify designated provider that they were admitted to a facility.
- Health Home can also determine status using the DSS Phone system (IVR) or the Card Swipe (emdeon).

4. Comprehensive Transitional Care Continued

- Health Home must have agreements or a method in place to receive notification when a recipient is admitted to the hospital or seen in an ER within 24 hours as well as any transitions that may be occurring to ensure that they receive information from other systems when a person is transitioning from one care setting to another or to home. The Health Home must also contact the recipient within the first 48 hours after the transition occurs. This will allow the Health Home to:
 - Facilitate interdisciplinary collaboration during transitions;
 - Provide comprehensive transitional care activities, including, whenever possible, participating in discharge planning; and
 - Collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing the recipient's and family members' ability to manage care and live safely in the community.

5. Recipient and family support services

- Recipient and family **support services** reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes.
- A defined member of the designated provider care team is responsible for engaging and educating the recipient/family about implementing the care plan using methods that are educationally and culturally appropriate.
- Assess barriers to care and working with the recipient/family to overcome barriers such as medication adherence, transportation and keeping appointments.
- Identify resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community.
- Provide information on advance directives in order to allow recipients/families to make informed decisions.

6. Referrals to community & social support services

- Referrals to community and social **support services** provide recipients with referrals to support services to help overcome access or service barriers, increase self management skills and improve overall health.
- Responsible for identifying available community-based resources and manage appropriate referrals.
- Coordinates or provide access to recovery services and social health services available in the community (may include housing, personal need and legal services).
- Provide assistance to obtain and maintain eligibility for health care, disability benefits, etc.
- Support effective collaboration with community based resources.

Health Home Referral Process

- Health Home recipients will be required to obtain a referral prior to seeing a provider other than their designated provider.
- Health Home Referrals now in electronic format found on the web at <http://dss.sd.gov/healthhome/forms.asp>.
- Health Homes should implement a process for obtaining resulting medical records, test results and/or procedure summaries when providing a referral.
- If the Health Home is the Community Mental Health Centers (CMHCs) as indicated by emdeon (card swipe) or IVR (phone system), the referral **must** start with CMHC.

Health Home Referral Process with a CMHC

If the CMHC is the Health Home Provider....

- CMHCs have been instructed to discuss with the recipient who their PCP is and to do a long term referral to the PCP for physical issues.
- These referrals should be placed in the EHR of the recipient by the PCP and then passed on when the recipient is referred to a specialist. Must use the Referral that began with the CMHC.
- Referral information should be shared back with the CMHC.
- When the PCP is identified, the PCP becomes part of the Health Home team. PCP should communicate with CMHC when recipient is referred elsewhere as well as other point of progress.

Management tools provided by DSS

- Each Health Home will receive data to help them manage their caseload.
 - Caseload Reports – will list all recipients attributed to the Health Home.
 - Will be sent in paper format at the beginning of each month.
 - It is important to monitor these reports month to month to see who has dropped off of your caseload as a result of losing eligibility for Medicaid or who has selected another provider.
 - It is also important to check eligibility for Medicaid at every visit.
 - Claims data – at the end of each month, claims data for each recipient will be loaded by clinic to a Secure FTP site. Clinic will need to use the provided username and password to view or download. Format provided on the web at <http://dss.sd.gov/healthhome/outcomemeasures.asp>.
 - Notice of Opt out – When a recipient chooses to remove themselves from the program, provider will receive a notice that they opted out and when the opt out took effect.
- Health Home quarterly trainings. <http://dss.sd.gov/healthhome/training.asp>
- Health Home Implementation Workgroup quarterly meetings.

Information Sharing about Health Home Recipients

- **Key federal and state regulations governing the release of behavioral health protected health Information (PHI)**
 - Federal law, specifically the Health Insurance Portability and Accountability Act (HIPAA), outlines the requirements for protection and disclosure of PHI. This information can be found in federal regulations 45 CFR Parts 160 and 164 and federal regulation 42 CFR Part 2 for Alcohol and Drug Abuse protected health information.
- **Physical and behavioral health providers can share a patient's behavioral health PHI**
 - If the patient has been notified of the potential release of this specific PHI and to whom. Proper authorizations to release PHI must contain specific references to behavioral health PHI. The client should be informed, at the time of authorization, that this specific PHI will be released to whom and for what purposes.
 - Providers should use the “minimum necessary rule” under HIPAA, to determine what behavioral health PHI should be shared. Providers must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request”.

Lessons Learned from other Health Homes

- Clinics where health homes have been implemented have found it to be challenging to ensure that **notification** happens in a timely fashion after an admission to facilities.
 - Clinic should have the necessary conversations with other Health Systems or independent facilities to ensure that notification is made within 24 hours.
- Integration between physical and behavioral health has also proven to be a challenge
 - Perform a standard assessment on every recipient to determine what if any behavioral health services are needed.
 - Make sure that your team includes (internal or external) someone who can deal with the behavioral health components if a PCP, or the physical health components if a CMHC. This integration is critical to the success of the program.
 - Make contact with the CMHC contacts in your area.

More Lessons Learned from other Health Homes

- Health Homes have found that recipient working through barriers and understanding the recipients social status is one of the most important indicators for success
 - Health Homes should continuously review the recipient's housing, legal and employment status to help determine what social support services are needed by the recipient.
- Health Homes have found it important not to reinvent the wheel.
 - Where possible leverage existing processes and initiatives currently being conducted in your facility i.e. Medical Home initiatives. Health Homes, however, must note the differences and be sure to comply with the Health Homes requirements.
 - Use the Health Homes requirements as an impetus to improve relationships and communications in areas where you may not have previously succeeded.
 - Physical and Behavioral Health Integration
 - Notifications from other facilities.

More Lessons Learned from other Health Homes

- Health Homes have found that it is important to educate everyone on Health Homes – Top to those answering the phones.
- Ongoing training and skill enhancement is important.
 - Participate in the sharing opportunities that DSS provides on a quarterly basis.
- Other states who have implemented Health Homes have indicated that Health Homes err on the side of caution when sharing information about recipients. Sharing information is an important component of a successful health home.
 - Signed agreement allowing data to be shared.

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Outcome Measure Requirements

Health Home Outcome Measures

- Health Homes require specific measures in the area of Clinical Outcomes, Experience of Care, and Quality of Care.
- Patient Experience Survey (standardized survey)
- Quality Plan has three goals with appropriate measures for PCP HH and CMHC HH
 - Minimum of one clinical indicator for each disease category
 - Patient and family experience/satisfaction measure
 - Cost and effectiveness measures
- Each Health Home will submit data electronically at the individual level every 6 months.

Submission Deadline	Data to be Submitted
August 31, 2015	January – June 2015
- Outcome measures and data file layouts are posted on the web at <http://dss.sd.gov/healthhome/outcomemeasures.asp>.

Health Home Outcome Measures Reporting

- Each Health Home will export the Outcomes Measure data in a file format outlined in the File Format. The File Format and instructions to submit the file can be found at <https://dss.sd.gov/healthhome/outcomemeasures.asp>
- DSS will provide claims data to complete the Outcomes Measure data.
- DSS will provide each Health Home the complete set of Outcomes Measure data at the Health Home level and will provide all Health Homes an aggregate report.

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How to Handle Recipient Issues

How to handle **difficult** recipient issues

- Two Types of Recipient Issues (processes found on the web at <http://dss.sd.gov/healthhome/orientation.asp>.)
- Behavior Issues - Goal is to experience minimal recipient issues, however if over time there are significant issues with a recipient, a disenrollment process has been established. - Review disenrollment process for behavior issues.
- Inability to Contact recipients – Review Disenrollment process for inability to make contact with recipient.

DSS Resources for Health Homes and Recipients

- Website <http://dss.sd.gov/healthhome/index.asp>.
- Health Home Card (Will be sent to all health home recipients with first letters.)
- Recipient Handbook has been updated with Health Home information. It is posted on the web at <http://dss.sd.gov/formspubs/docs/MEDSRVCS/MedicalAssistanceRecipientHdbk.pdf>
- Access to DSS Health Home team
 - (605) 773-3495
 - Kathi.Mueller@state.sd.us.

What makes a successful Health Home?

- **Integration** of clinical care, support services, internal and external resources.
- **Coordination** of all care, including prevention, primary care, specialty care, behavioral health, hospitalization and transitions.
- **Communication** vertically and horizontally – within the Health Home, with the recipient and family members, with others involved in the care process.
- **Access** to health coaches, designated providers, the right clinical setting, and
- **Education** for the recipient and family, the Health Home, clinical and social support referral sources.

PCP Success Story

- **Demographics:** Male, 63 years old, truck driver
- **Medical Issues:** Diabetes Mellitus and Coronary Artery Disease
- **Mental Health DX:** None
 - HgA1c=9.1 weight 280#, and B/P= 138/87. Not exercising.
 - We worked on diet and exercise and he set goals. He was very motivated to not lose his license for truck driving.
 - 3 months later: exercising 4-5 times/week. Replaced unhealthy snacks with healthier choices and reduced portion size. He quit drinking soda and increased his water intake daily
 - HgA1c=5.1, weight 245# and B/P=110/70.

CMHC Success Story

- **Demographics:** Female client, age 22
- **Medical Issues:** Multiple Medical Issues
- **Mental Health DX:** Borderline Personality Disorder and Major Depression
 - When we began working with this client in the HH program, she was residing as an inpatient at Avera McKennan Hospital (main hospital, not behavioral health) for most of two years following a serious car accident.
 - She was bed ridden and unable to walk on her own. She also had a history of doing things such as re-opening wounds when she was close to discharge from the hospital as a way of prolonging her stay.
 - Today, she resides at a long-term care facility but is now walking independently.
 - She has stopped re-opening her wounds and her remaining wound is almost entirely healed.
 - She is next on the waiting list at our Cayman Court assisted living facility and given her remarkable progress, she should be able to take another step toward becoming more independent.

South Dakota Health Home Orientation **Questions and Thank You!**